

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
JOHN FRANKLIN DAVIES						Jan 15 1968			M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	June 5, 1878	89 YRS.					Jan 15 1968	M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Amherst, Va.		USA				QUEEN ANNES			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Queenstown						Retired - Insurance		Insurance	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Queen Anne			Queenstown			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
JOHN FRANKLIN DAVIES			CAROLINE SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT (son)			ADDRESS Balto. Md. 21212
Yes			Sp. American 218-32-1308			Mr. Landon B. Davies, 108 E. Melrose Av.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio Vase</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ar disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u> years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>C. R. Layton</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>Jan 15 1968</u>			
EXAMINER'S NAME (Type) <u>C. R. Layton</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <u>Centreville Q A Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 18, 1968		Druid Ridge Cemetery		Pikesville, Balto. Co., Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
STEWART & MOWEN CO. 108 W. North Av., Balto. 1						JAN 17 1968		<u>Charles Judge</u>	

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Page 1 of 1

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## CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>Susie</b>			First <b>A.</b> Middle <b>Johnson</b> Last			2a. DATE OF DEATH Month <b>1</b> Day <b>13</b> Year <b>68</b>			2b. HOUR M		
3. SEX <b>Female</b>			4. RACE <b>Colored</b>			5. DATE OF BIRTH <b>12/29/1884</b>			6. AGE (In years last birthday) <b>83</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Queen Anne's Co.</b> Md.		
10. CITY OR TOWN OF DEATH <b>Pondtown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Anthony Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Labor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Kent</b>			13c. CITY OR TOWN <b>Chestertown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <b>John</b> Middle <b>Walley</b> Last			15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Unk.</b> Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No.</b>			16b. SOCIAL SECURITY NO.		
17. INFORMANT <b>MR. Edgar Johnson</b>			Address <b>R.F.D. Chestertown, Md.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4129</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several</b> <b>years</b>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>66</b> , to <b>1-13</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>1-13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert W. Farr</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>1-20-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Robert W. Farr M.D.</b>			22e. ADDRESS <b>Chestertown, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>1/20/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Methodist Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Chestertown Kent Md.</b>		
24. FUNERAL DIRECTOR <b>Emmanuel Walley</b>			ADDRESS <b>Chestertown, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 23 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print) <b>Charles Royal</b>						2a. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>68</b>			2b. HOUR <b>12 P.</b> M.				
3. SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>2/15/1886</b>			6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne's County</b> Md.							
10. CITY OR TOWN OF DEATH <b>Millington</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bessie Downes Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Labor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Queen Anne's</b>		13c. CITY OR TOWN <b>Centreville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>RD #1</b>				
14. FATHER'S NAME First Middle Last <b>Joseph Royal</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Virginia Wilson</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Bessie Downes</b>				Address <b>R.F.D. Chestertown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> <b>4299</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cardiac decompensation</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>2 days</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>491x</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 5, 1968</b> , to <b>Jan 16, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Jan 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Geza Koralewski</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 17-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Koralewski Geza M.D.</b>				22e. ADDRESS <b>Millington, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carmichael Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Queentown, Md</b>							
24. FUNERAL DIRECTOR <b>Samuel W. Wally</b>				ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

<div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>01592 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01584</div>									
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHESTERTOWN</u>			c. LENGTH OF STAY in 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHESTERTOWN</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK ULYSSES SMITH</u>					4. DATE OF DEATH Month Day Year <u>JANUARY 12 1968</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 9 - 1874</u>		9. AGE (in years last birthday) <u>93</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>xx</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE SMITH</u>					14. MOTHER'S MAIDEN NAME <u>HARRIET STEVENS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT Address <u>MRS. ARTHUR HOCK-CRUMPTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4129</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <u>disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u>									INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>C. Rodney Layton</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>1-13-68</u>	
EXAMINER'S NAME (Type) <u>C. RODNEY LAYTON</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Centerville, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 14</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON</u>		23d. LOCATION (City, town or county) (State) <u>CRUMPTON MD.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Edgar L. Kane - Church Hill, Md.</u>					25a. REC'D BY REGISTRAR <u>JAN 18 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

7-170

WAS. C. 170. CHRONOLOGICAL INDEX

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

VR 15-1  
30M RE 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>JESSIE</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>January 6, 1968</b>			2b. HOUR a <b>9:20 PM</b>		
3. SEX <b>Male</b>			4. RACE <b>Colored</b>			5. DATE OF BIRTH <b>Unknown, 1904</b>			6. AGE (In years last birthday) <b>63</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Queen Anne's</b> Md.		
10. CITY OR TOWN OF DEATH <b>Near Millington</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Kent</b>			13c. CITY OR TOWN <b>rural Galena</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME <b>Clifton</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Sadie</b>			First Middle Last <b>Taylor</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Sister</b>			Address <b>Galena, Md. 21635</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>431.0 cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hyper-tension</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 days</u> <u>one year</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>332x</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1968</u> , to <u>Jan 6, 1968</u> , that (I) (we) lost the deceased alive on <u>Jan 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Geza Koralewski</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>1.8.68</u>		
22d. PHYSICIAN'S NAME (Type) <b>Geza Koralewski. M.D.</b>						22e. ADDRESS <b>Millington, Md. 21651</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Jan. 10, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Morgan Neck Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Chestertown, rural, Kent, Md.</b>		
24. FUNERAL DIRECTOR <b>Edward Fellows &amp; Son,</b>						ADDRESS <b>Millington, Md. 21651</b>			25a. REC'D BY REGISTRAR <b>JAN 10 1968</b>		
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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FOR STATE  
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01586

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Howard S. Wallace						Month Day Year			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	Feb. 7, 1912	55 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	1967		4:20 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md.	
Md.		U.S.A.		WIDOWED		DIVORCED		Queen Anne's			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rural Millington						Farmer			Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Queen Anne's			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Thomas Wallace			Bessie Mayberry								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No.			222-05-3146			Mrs. Alberta Wallace, Rural			Sudlersville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Exposure to cold									many hours		
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Acute Alcoholism									10 day		
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9328 Known Chronic Alcoholism											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input checked="" type="checkbox"/>			HOUR A.M. P.M.			Date 1967					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.T.D. No.			City or Town		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			Robert Price Farm			Rural			Millington Q.A. Md.		
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
Noturof cause <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)		
C. R. Layton						JAN 3, 1967			Centerville Md		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Jan. 7, 1968		Sudlersville Cemetery		Sudlersville, Q.A. Co;		Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Edward Fellows & Son, Millington, Md. 21651						DATE JAN 5 1968		J. Charles Jones			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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